



The Northwest Catholic Counseling Center

Providing help, creating hope...

Informed Consent and Notice of Privacy Practices

This Consent Form is to provide an explanation of treatment, the risks associated with treatment, and The Notice of Privacy Practices for Protected Health Information (PHI) regarding _____.

(Print name of person to receive services)

In addition to the above reasons, this form is to also give consent for treatment at The Northwest Catholic Counseling Center (NCC). When we use the word “I” or “me” below, it will mean yourself, your child, relative, or other person you have legal guardianship of and for whom you can give consent to share information and to receive treatment.

I understand that as a client of NCC, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to establish the best course of treatment. The information you provide will remain confidential with some exceptions allowed by law and the prescriber and/or counselor code of ethics as described in the remainder of this document.

While getting services at NCC, it may be necessary for staff to communicate, consult, or coordinate with other NCC staff. Written authorization for such communication within NCC will not be requested. Prior to any discussion with other NCC staff, I understand that I will be informed as to what communications will be exchanged. In other circumstances for exchanging information outside of NCC, a written consent to release information will be obtained from you.

I further understand that there are specific exceptions to keeping confidentiality where a clinician is ethically and/or legally bound to take necessary steps to prevent harm to myself or to others:

1. When there is risk of harm to myself or someone else.
2. When there is suspicion that a child, person with a disability, or an elder is at risk of or is being sexually, physically, or emotionally abused or neglected.
3. When a valid court order is issued for disclosure of information or records

I understand that while mental health services, assessments, and/or medication, may provide significant benefits, they may also pose certain risks. Counseling and assessments may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Change may occur for the individual in treatment. The family or other relationships may resist the changes made. Assessments may reveal the need for more intensive treatment. Medications may have unwanted side effects.

(Signature required on second page)

A State Certified Counseling Agency

Donations are tax-deductible. Tax ID 93-1088966

8383 N.E. Sandy Boulevard, Suite 205 • Portland, Oregon 97220 • 503.253.0964

www.nwcounseling.org

The PHI we collect is used for treatment, consultation, billing, and care coordination, therefore, the law allows us to share this information with others who also provide treatment for you or to arrange payment for your treatment or for other business or government functions such as demographic data collection. The Notice of Privacy Practices explains in more detail your rights and how we are able to use and share this information. You received a copy of The Notice of Privacy Practices with your intake paperwork.

In the future, Federal law may require additional changes to our Notice of Privacy. If so we will notify you if you are still an active client at the Center. Any change will be posted on our web site, www.nwcounseling.org.

If you are concerned about some of your information, you have the right to ask us not to use or share that information for treatment, payment or administrative purposes. You will have to make your request in writing. If it is in regards to sharing information for payment purposes, you may be held responsible for payment. We will attempt to respect your wishes when in compliance with Federal law.

Signature of client or personal representative

Date

Printed name of client or personal representative

Please initial: _____ I received a copy of the Notice Of Privacy Practices

For Clinician use only: _____ I have verbally discussed exceptions to confidentiality with client.
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Client Consent and Guide to EMAIL Use

The decision to utilize email is strictly voluntary and your consent may be rescinded at any time. There are risks to using email to communicate with your counselor/prescriber. The risks are but not limited to:

- **NCC's Email is not encrypted, therefore, not confidential**
- Email may be seen by unintended viewers
- Email may be intercepted by hackers and redistributed
- Someone posing as you could communicate with the counselor and access information
- Email can be used to spread computer viruses
- Email may not be received by either party in a timely matter
- Email is discoverable in litigation and may be used as evidence in court
- Email can be circulated and stored by unintended recipients
- Statements made via email may be misunderstood creating miscommunication and/or negatively effecting treatment

When may I use email to communicate with my counselor?

- Appointment scheduling or rescheduling
- Clarification on therapeutic homework
- Other matters not requiring an immediate response

When should I **NOT** use email to communicate with my counselor?

1. **In an emergency:**
 - If you are experiencing any desire to harm yourself or others
 - If you are experiencing a severe medication reaction
2. If you need an immediate response about non-emergent issues

What can I expect from my counselor/prescriber around answering my emails?

- Your email will be read within 48 business hours.
- If the counselor/prescriber deems it to be clinically inappropriate to respond, a conversation about the email will be initiated at your next appointment.
- If the original email initiated by you is cc'd to a third party, NCC may chose not to respond or may not include the third party in the response.
- NCC counselor/prescriber will not initiate emails containing clinical content.
- **If you initiate an email with clinical content, you are accepting the risk.**

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What happens to my messages?

- Email will be printed out and maintained as a permanent part of your medical record
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when NCC is legally required to do so
- Messages may be seen by staff for the purpose of filing or carrying out requests

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and my counselor/prescriber at NCC. I recognize there are risks to its use, and NCC cannot absolutely guarantee confidentiality. I understand and accept those risks. I further understand if I send too many emails, send inappropriate emails, or copy outsiders on the emails, NCC may not respond or cease to allow me to use email to communicate with NCC. I also understand that I may withdraw my consent to communicate via email at any time by notifying my counselor/prescriber in writing.

Print Name of Client _____

Typed name of Patient/Guardian valid as signature Date

Email Address: _____

☐ I am choosing to opt out. I do not give consent for NCC to use email to communicate with me. I understand that if I change my mind and want to email NCC, I will need to sign a consent form (Check box and sign below).

Sign here if opting out: _____



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Child/Adolescent Psychosocial History

Date _____

Client ID _____

(office use only)

Please provide the following information for your child/adolescent. It will be held to the same standards of confidentiality as the therapy itself.

Child/Adolescent Name _____
First Middle Last

Address _____

City State Zip

Birth date: _____ / _____ / _____

Gender: Female Male Transgender Other Pronouns: _____

Does your child/adolescent identify as LGBTQ? Yes No

Person completing this form: _____

Relationship to child/adolescent: _____

Mother's Name: _____

Best phone # to reach: (cell) (home) _____ - _____ - _____

May we leave a message? Yes No

Father's Name: _____

Best phone # : (cell) (home) _____ - _____ - _____

May we leave a message: Yes No

For appointment reminders, we can text, email, or call. Who should be notified for appointments and how do you want to receive notification?

Who: _____ **How:** _____

Ethnicity: (Choose all that apply:

American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Pacific Islander White

Multi-ethnic _____

Other _____

Prefer not to answer

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Legal Information

Who has custodial guardianship? _____

(You may be asked to provide copy of custodial guardianship)

Stepparent (if applicable) _____

Are you, as the parent or stepparent, involved in any legal proceedings such as divorce, custody disputes, etc? Yes No

If yes, please explain _____

Has your child been involved in the legal system? Yes No

If yes, please explain _____

Medical, Psychological and Developmental History

List any pregnancy or delivery complications or problems. _____

Describe any significant medical/developmental history for your child/adolescent including hospitalizations (medical or psychiatric), significant losses, and gaps in living with attachment figures.

Has your child/adolescent experienced any traumatic events? _____

Has your child/adolescent ever attempted or expressed the desire to commit suicide?

Explain: _____

Has your child had any previous counseling? ☐ Yes ☐ No

If yes, with whom and when? _____

Do you have any concerns regarding your child/adolescent use of alcohol/drugs? _____

Does your child/adolescent have a disability defined as substantially limiting movement, sensory, social, employment, or learning activities? No Yes Is it documented? No Yes

Office use only:

____ Entered in FM ____ Entered in TH ____ Scanned

Name of pediatrician: _____

When was the last time your child/adolescent saw the pediatrician? _____

Does your child/adolescent take any medications? Yes No

If yes, please list all medications and dosages.

Medications:	Dosage:
_____	_____
_____	_____

List any allergies: _____

Has anyone in your family (either immediate family or relative) experienced difficulties with the following? Check any that apply and list family member (sibling, parent, uncle, etc).

- | | | |
|--------------------------|-------------------------|-------|
| <input type="checkbox"/> | Depression | _____ |
| <input type="checkbox"/> | Anxiety | _____ |
| <input type="checkbox"/> | Schizophrenia | _____ |
| <input type="checkbox"/> | Eating Disorder | _____ |
| <input type="checkbox"/> | Trauma | _____ |
| <input type="checkbox"/> | Bipolar | _____ |
| <input type="checkbox"/> | Panic Attacks | _____ |
| <input type="checkbox"/> | Alcohol/Substance Abuse | _____ |
| <input type="checkbox"/> | Suicide Attempts | _____ |

Social/Educational Information

Please list names and ages of other children living in the home.

Name	Age
_____	_____
_____	_____
_____	_____

Please describe your child/adolescent interaction with other family members. _____

Are there any family stressors (financial, marital, peers, etc) that might be affecting your child?

☐ Yes ☐ No

If yes, please explain. _____

School: _____

Grade: _____

Please describe your child/adolescent's academic performance. _____

Please describe your child/adolescent's social interaction at school. _____

List hobbies, sports, music, TV shows, toy preferences, etc. _____

How is discipline generally handled in the home? _____

Describe your child/adolescent strengths. _____

Concerns and Symptoms

What are your specific concerns for your child/adolescent that have brought you to counseling?

What are your goals for your child/adolescent's therapy? _____

Is there any other information that you believe would assist the therapist in understanding your child?

Please check behaviors and symptoms that occur to your child/adolescent more often than you would like them to take place.

- | | |
|---|---|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Oppositional |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Blinking, jerking | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Clumsy | <input type="checkbox"/> Quarrels |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Sad |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Separation anxiety |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Slow moving |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Head banging | <input type="checkbox"/> Suicidal threats |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Talks back |
| <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Ticks or twitching |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Unsafe behaviors |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Unusual thinking |
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Loner | <input type="checkbox"/> Worries excessively |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Other |
| <input type="checkbox"/> Messy | |
-



National Center for

PTSD

POSTTRAUMATIC STRESS DISORDER

PTSD Checklist for *DSM-5* (PCL-5)

Version date: 11 April 2018

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. Available from <https://www.ptsd.va.gov/>

URL: <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>

Note: This is a fillable form. You may complete it electronically.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

General Anxiety Disorder (GAD-7)

NAME _____

DATE _____

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or Irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>				
TOTAL SCORE <i>(add your column scores)</i>				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Patient Health Questionnaire (PHQ-9)

Patient Name: _____

Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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FEE POLICY

The Northwest Catholic Counseling Center's primary interest is to provide you with quality and affordable care. For counseling our fee is \$160.00 for the first session and \$140.00 thereafter. In the event of financial difficulty, your fee can be negotiated to an amount you are more comfortable paying. For this reason, we wish to clarify the following policy regarding your fee.

Your fee is due and payable at the time of each session. If payment is not made at the time of the counseling session, your balance is not to exceed 30 days. If your balance reaches four sessions, you will not be allowed to schedule additional sessions until there is some payment activity on your account. There is a \$20.00 service charge for all returned checks.

As a courtesy, we will make every effort to bill your insurance company. You are responsible for your deductible as well as any remaining balance the insurance company does not pay. If an overpayment is made to your account from an insurance payment, your account will be credited.

If cancellation of your appointment is not received 24 hours in advance you will be charged \$60.00 for your missed appointment. Insurance cannot be billed for missed appointments.

I agree to the following (check all that apply):

☐ Insurance Payments (EAP, HMO, etc.):

I understand and agree to pay \$_____ as my co-pay for each session. Co-pays are based on your insurance benefits.

☐ Self-Pay: Counseling Session:

For the initial appointment, I agree to pay \$_____. This is a one-time fee due at time of service.

For follow up appointments I agree to pay \$_____. This is due at time of service.

☐ Third-Party Payer (insurance excluded). It has been arranged that:

Name: _____ Phone: (____)_____

Address: _____

City: _____ State: _____ Zip: _____

I understand if they do not pay, I am responsible for the bill.

I HAVE READ THIS FEE POLICY AND AGREE TO PAY THE FEE NEGOTIATED AND WRITTEN ABOVE. I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE COVERAGE, OR THIRD-PARTY PAYER, THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT.

Client Signature

Date



The Northwest Catholic Counseling Center

**Only fill out this form if you are using insurance. NCC does not accept Medicaid or Medicare*

**Please include a copy of the front & back of your insurance card.*

Assignment of Medical Benefits

Client Name: _____

Date of Birth: _____

Primary Insurance Co: _____

Policyholder Name: _____

Date of Birth: _____

Member ID#: _____

Group #: _____

Insurance phone number for eligibility/benefits: _____

I authorize payment of medical benefits to The Northwest Catholic Counseling Center for any services rendered to me or my dependents while a client at the Center. This assignment will remain in effect until revoked by me in writing. I hereby authorize The Northwest Catholic Counseling Center to release all information necessary to secure the payment of my benefits.

Signature of client or their representative

Date